STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	08/08/2013

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: July 30, 31, August 1, 2, 5, 6, 7, and 8, 2013 Facility number: 000084 Provider number: 155167 AIM number: 100284600 Survey team: Karina Gates, Generalist, TC Courtney Mujic, RN (July 30, 31, August 2, 5, 6, and 7, 2013) Suzanne Williams, RN (July 30, 31 and August 5, 2013) Tom Stauss, RN (August 5, 6, 7 and 8, 2013) Census bed type: SNF: 40 SNF/NF: 59 Residential: 81 Total: 180 Census payor type: Medicare: 23 Medicaid: 51 Other: 106 Total: 180 Residential Sample: 8	F000000	Submission of this plan of correction shall not constitute or be construed as an admission by Westminster Village North that the allegations contained in this survey report are accurate or reflect accurately the provision of nursing care and service to the Residents at Westminster Village North.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quaity review completed on August 16, 2013, by Janelyn Kulik, RN.			

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F000241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to ensure a resident's dignity was maintained during dining, for 1 resident randomly observed during dining (Resident #14). Findings include: During observation of lunch on the Woodside Unit, on 7/30/13, Resident #14 was being fed by CNA #10 from 1:15 to 1:25 p.m. The resident was in her chair at a round table; the CNA was sitting behind the resident and feeding her. The resident's head was turned to the right side when she took bites of food from the CNA. The CNA was not in the resident's view. When the resident saw the spoon appear in her line of vision, she would turn her head and take a bite. Interview with the Woodside Unit Manager, on 7/30/13 at 1:42 p.m. indicated she will talk to the CNA about the way she was feeding the resident.	F000241	The facility is committed to providing dignity for all of our Residents. Regrettably, Resident #14 presents with some unique challenges in terms of her individual needs in regards to feeding the Resident due to her dysphagia. Staff had been instructed that they should be positioned in a manner that would allow them to visualize the Resdient swallowing. Subsequent to this event, Nursing, Dietary, Speech Therapy, and Occupational Therapy have worked in concert to ensure that the best strategies are designated for use by this Resident. The Speech Therapist and the Occupational Therapist have observed this Resident during meal service and have (again) instructed the staff regarding the proper techniques to utilize with this Resident, as well as the optimal positioning of the staff while feeding the Resident. Although the staff member was seated BESIDE the Resident at the time of surveyor observation, it would have been preferable for the staff member's chair to have been a few inches forward to allow for	08/30/2013

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	3.1-3(t)		optimal observation of the Resident as she was swallowing. All recommendations for Resident #14 have been noted on the C.N.A. Assignment Sheet and on the Resident's care plan. Said recommendations have also been placed in front of the Resident's Medication Record so that it will be readily accessible to all of the nurses as they circulate in the dining room and observe Resident #14. Prior to this citing, it has always been a practice of the Therapy Department to perform weekly observations of all the facility's Dining Rooms during meal service in an effort to identify any Residents that may benefit from specific interventions to enhance dignity, meal consumption, and the overall dining experience. This will be a permanent task for the therapy department and will never cease. The therapy department is responsible. The therapy director will monitor. The findings of thier observations will be reviewed in the facility's monthly QA meetings on a permanent basis. The therapy department will also, specifically, observe resident #14 on a weekly basis during meal service for the duration of the resdients stay in the facility. Finding of thier observations regarding resident #14 will also be reviewed during the monthly QA meetings during the duration of the residents stay in the facility. Subsequent to this citing,	

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			however, dining observations have been done: no other Residents were identified as needing any new interventions for the enhancement of their dignity, meal consumption, and dining experience. Thus, the facility ruled out the possibility that other Residents had been afffected by this practice. The Therapy Department as well as nursing personell will be making periodic observations of Resident #14 during meal service in an effort to ensure that staff compliance with this Resident's plan of care is maintained. Specifically, the Unit Coordinator will perform daily (on scheduled days of work) observations of this resident during meal service ongoingly, for the duration of the resident's stay in the facility. The Unit Coordinator will report the results of said observations during the facility's monthly QA meetings for the duration of the resident's stay. The Unit Coordinator is responsible. The DON will monitor.	

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to ensure a resident receiving an antipsychotic medication daily had a care plan for its use for 1 of 20 residents reviewed for care plans. (Resident #5) Findings include: The clinical record for Resident # 5 was reviewed on 8/6/13 at 1:30 p.m. The diagnoses for Resident #5 included, but were not limited to: psychosis.	F000279	As noted in the surveyor's commentary, the approriate care plan was established for Reident #5 upon discovery. Additionally, on 8/6/13, all medical records were audited to ensure that the appropriate care plan was in place for any Resident that required the use of an antipsychotic medications. This was done to ensure that no other Residents lacked care plans addressing the use of antipsychotic medications. Subsequent to this citing, an inservice has been scheduled for 8/28/13, with the Consultant Pharmacist, for an	08/30/2013

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	The August, 2013 Physician's Orders for Resident #5 indicated she was to receive 5 mg of olanzapine (an antipsychotic medication) daily effective 2/12/13. The August, 2013 MAR (medication administration record) for Resident #5 indicated she was receiving the olanzapine daily as ordered. During review of Resident #5's care plans, no care plan regarding her olanzapine use was found. During an interview with Unit Manager #3 on 8/6/13 at 2:35 p.m., she looked through Resident #5's care plans and indicated she did not see a care plan addressing Resident #5's olanzapine use. She stated, "The social worker would make that care plan." During an interview with the SSD (Social Services Director) on 8/6/13 at 3:10 p.m. regarding lack of a care plan regarding Resident #5's olanzapine use, she indicated she created care plans when she reviewed charts. She indicated her last review of Resident #5's chart was in April, 2013 and she "most definitely" missed it upon review. She stated, "I'm going to go do it right now because I don't see it in there." She		inservice for the Administrative Nursing staff for additional education regarding antipsychotic medications. Additionally, the Social Workers will conduct monthly audits of care plans to ensure that a care plan is in place addressing the use of antipsychotic medications for all applicable Residents. To facilitate the timely initiation of care plans for future Resident's newly requiring the use of antipsychotic medications as well as timely updates of the care plans based upon order changes to the Resident's medication regime, going forward, copies of all such orders will be forwarded to the Social Services Department. The facility's Social Workers are responsible. The Social Services Director will monitor. The results of said monitoring will be reviewed during the facility's Quality Assurance Meetings.	

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	further indicated the information that needed to be included in the care plan would be "side effects, GDR (gradual dose reduction), contact physician and mental health for changes in behaviors, different approaches for the use of it." On 8/7/13 at 10:30 a.m., a copy of Resident #5's 8/6/13 care plan addressing her olanzapine use was provided. 3.1-35(a)			

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F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview, and record review, the facility failed to update a pressure ulcer care plan for 1 of 20 residents whose care plans were reviewed. Resident #120. Findings include: Resident #120's clinical record was reviewed on 8/6/2013 at 10 am. Diagnoses included but were not limited to; acute renal failure, Alzheimer's dementia, anemia, and malnutrition. An interview with the Director of	F000280	Resident #120 was in the group of discharged records that were reviewed by the surveyor. Thus, there is no corrective action that can be executed at this time for this specific Resident. As noted in the surveyor's commentary, the care plan for this Resident's pressure ulcer included the approach "treatment as ordered". This has been the practice of the facility for many years, the rationale being that the specific treatment orders for each Resident are readily available on the Resident's Treatment Administration Record and in the Physician's Orders. Furthermore, the practice of the use of the statement "treatment as ordered"	08/30/2013

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	Nursing, on 8/6/2013 at 2:26pm, indicated the Unit Coordinators are responsible for updating the pressure ulcer care plans as needed, when there is a significant change. There is no specific policy related to updating a care plan. An interview with Unit Coordinator #4, on 8/6/2013 at 2:30 pm, indicated, "if a change in wound treatment happened it would've been put on the treatment sheet, and verbally exchanged from the nurse to the CNA's. The CNA assignment sheet would've been updated, this gets updated daily. The Unit Coordinator updates the CNA assignment sheet. They aren't a part of the record." She also indicated she didn't know she should be putting each new treatments onto the care plan. A 'Non-Compliant with MD orders to turn from side to side', care plan, dated, 5/10/2013, indicated, "Problem: Wound to mid back. Interventions: Keep skin clean and dry via scheduled toileting, incontinent care, and good daily hygiene. MVI (multivitamin) as ordered. Assist/remind to turn and reposition q (every) 2hrs and PRN (as needed). Pressure reducing/relieving mattress and chair cushions as indicated. Keep		has never been problematic in previous surveys. Nonetheless, it is the facility's desire to gain and maintain compliance with F 280. Therefore, the care plan policy has been ammended to note that care plans for pressure ulcers will be updated when a change in treatment occurrs. In the future, care plans addressing a Resident's pressure ulcer will denote the specific treatment and will be updated when ever the treatment is changed. Typically, a wound care specialist assesses any resident with a pressure ulcer on a weekly basis. Going forward, the Unit Coordinators will be responsible to review the orders (if any) from the wound care specialist at the time of each visit and update the resident's care plan to denote the specific treatment that tis ordered. The DON will monitor by review of any ordersw and the corresponding care plan. The Unit Coordinators are responsible for said updates of the presssure ulcer care plans. The Director of Nursing will monitor. Additionally, the agenda of future Quality Assurance Meetings will be expanded to include the compliance with the desired updates of care plans addressing pressure ulcers on a monthly basis.	

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	bed linens clean and free of wrinkles and foreign matter. Avoid friction or shearing movements with transfers and bed mobility. Weekly visits from wound team. Treatment as ordered." A 'wound care specialist' note, dated 6/21/2013, indicated, "Wound #1: Lumbar spine is a necrotic tissue (unstageable) pressure ulcer... Plan: Cleanse wound bed with NS (normal saline). Pat dry. Apply skin prep or barrier cream to periwound. Apply hydrogel moistened, fluffed gauze to wound bed followed by dry gauze and secure daily and PRN (as needed) when soiled. May secure with [brand name] foam. Pressure ulcer upper back: Will continue the hydrogel moistened gauze and dry gauze then transparent film." 3.1-35(d)(2)(b)			

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F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to provide oral care as care planned for 1 resident reviewed of 1 who met the criteria for activities of daily living, cleanliness, and grooming. (Resident #45) Findings include: The clinical record for Resident #45 was reviewed on 8/5/13 at 10:00 a.m. The diagnoses for Resident #45 included, but were not limited to: heart failure and peripheral vascular disease. The 6/20/13 quarterly MDS (minimum data set) assessment for Resident #45 indicated she required extensive assistance of 1 person for personal hygiene. The 6/12/13 Dental/Oral/Nutrition Assessment indicated Resident #45 had an upper denture.	F000312	As noted by the surveyor, Resdient #45 had never voiced a concern to the staff regarding a problem with the alignment of her denture. Furthermore, this Resident had never voiced any concerns to the staff regarding her denture care. It is also noteworthy that this Resident's BIMS = 15. A dental appointment has been scheduled for this Resident for the assessment of the misalignment of the teeth in her upper denture. Each of the Unit Coordinators conducted an audit of the Resdients on their unit to ensure that all Residents that require the use of dentures have the same noted on their care plan and the C.N.A. assignment sheet. All Nursing Assistants will (again) be inserviced regarding oral hygiene to ensure that Residents with dentures or their own natural teeth are provided with appropriate oral hygiene. The Quality Assurance Nurse and other administrative nurses will be responsible for conducting weekly audits on random residents regarding regarding denture care/oral hygiene. Furthermore, resident #45 will be asked daily	08/30/2013

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	During an interview with Resident #45 on 7/31/13 at 2:05 p.m., she indicated the staff did not soak her upper denture. She stated, "I did that at home, but not here. They brush them off maybe a couple times a week...I'd be okay if they soaked them." At this time, Resident #45 was observed with an upper denture in her mouth with one of the teeth hanging down further than the rest, not in alignment with the other teeth. Resident #45 pointed to the tooth and stated, "This tooth came down...The facility hasn't said anything about it. I haven't told them either." The 1/2/13 ADL (activities of daily living) deficit care plan indicated interventions as follows: "7. Provide appropriate level of assist daily with all physical functioning and self care areas: ...personal hygiene... 8. Oral care BID (twice daily). Set up and assist PRN (as needed)... 10. Use of personal hygiene products to promote cleanliness and comfort: deodorant, lotions, powders, perfumes, mouthwash, etc." During another interview with Resident #45 on 8/5/13 at 10:37 a.m. she indicated, "At home I did it every night. It would be nice if they did it at		by nursing personnel regarding her satisfaction with her denture/oral care. Results of the random audit and the consultation with resident #45 will be reviewed during the facility's monthly QA meeting and will be a permanent component of the agenda going forward. The DON will monitor.	

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	least every other night...They did not do it last night. They have never soaked my dentures and I've been here several months. I don't have any solution in here either...One day last week, an aide came and rinsed them off, but they've never been soaked overnight or soaked at all." On 8/5/13 at 2:36 p.m., an interview regarding denture/oral care was conducted with QMA #4, a previously assigned direct care staff to Resident #45. She indicated she helped put residents to bed at night. She stated, "I take the dentures out, rinse them, use (name of denture cleaner), and use mouthwash to clean the gums. Sometimes I have (name of Resident #45). She is total assist. The last time I cared for her was 2 weeks ago. I have cleaned her dentures before. She keeps her (name of denture cleaner) in her drawer. That is where I got it from when I cleaned it a couple weeks ago." On 8/5/13 at 2:37 p.m., an interview regarding denture/oral care was conducted with CNA #5, the currently assigned direct care staff to Resident #45. She indicated the last time she helped Resident #45 with bedtime care was 2 Saturdays ago. She stated, "I didn't know she had			

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	dentures. No, I didn't soak them 2 weeks ago. I've never soaked her dentures. I've only done her bedtime care 1 time, 2 Saturdays ago and I didn't know she had dentures. If I had known, I would have soaked them in a cup with a denture tube, so they would get nice and clean." Regarding whether Resident #45 had any denture cleaner in her room, she stated, "If it's not in her drawer, it should be in her bathroom." On 8/5/13 at 2:45 p.m., an observation of Resident #45's room was made with CNA #5. CNA #5 looked in the drawers and the restroom. No denture cleaner was found. Resident #45 stated, "I don't have any here." An interview was then conducted with Unit Manager #3 on 8/5/13 at 2:51 p.m., she stated, "She doesn't have dentures." Unit Manager #3 then looked in Resident #45's chart and stated, "Oh, it does say she has upper dentures. I'm going to have one of the CNA's soak her dentures. We'll get her some cleaner too." 3.1-38(a)(3)(C)			

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	155167	A. BUILDING 00 B. WING	08/08/2013

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F000323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a soiled utility room containing a box labeled "biohazard" was kept locked to prevent potential accidents for 16 independently mobile residents of 22 residents residing on the dementia unit. The facility also failed to ensure a needle was safely disposed of in order to prevent potential accidents during 1 of 30 medication administrations observed. Resident #188. Findings include: 1.) On 7/30/2013 at 11:38 am indicated an observation of a room on the Cedar Commons dementia unit, across from the nurse's station near room 70, was a room labeled 'Soiled Utility'. The door to the room was shut, and had a key-pad type lock panel on the doorknob, but the door was unlocked. The nurse's station desk was empty, and there were no staff around. Inside the 'Soiled Utility'	F000323	1) At the time of discovery the door was secured shut. Please note that no residents were affected. Subsequently, the door closure mechanism that was present was adjusted so that the door would automatically close shut. This was done immediately following the discovery of this. Additionally, all doors to rooms in the health center that contained chemicals were inspected to ensure that door closures were in place and functional, rendering the doors to positively latch. As a means of on-going quality assurance, the inspection of such doors will be added to the safety audit sheets that are utilized by the safety committee so as to monitor the efficacy of the door closure mechanisms to the doors of the rooms that contain chemicals. The results of the audits will be discussed at each Safety Committee Meeting going forward. Additionally, maintenance personnel will be responsible, under the supervision of the Plant Operations Manager, to monitor the doors on a weekly basis to ensure that they are functional and positively latch. The results	08/30/2013

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	room, in the far corner on the floor, was a box labeled 'biohazard' which contained tied red bags. An interview with Unit Coordinator #3, on 7/30/2013 at 11:50 am, indicated the door should be locked, "one of the girls (an aide) must not have pulled it shut all the way". She also indicated she would tell the aides to make sure to pull it shut tightly from now on. A 'list of cognitively impaired residents who are independently mobile' on the dementia unit, was provided by the Quality Assurance RN, on 8/8/2013 at 2:35 pm. The list indicated the following resident's were highlighted to indicate they were cognitively impaired and independently mobile, Resident #'s; 138, 111, 131, 97, 129, 139, 124, 60, 56, 38, 178, 179, 250, 251, 252, 253. 2.) An observation, on 8/8/2013 at 9:15 am, of a medication administration with LPN #2 indicated she administered a [name of medication] subcutaneous injection into Resident #188's abdomen. LPN #2 then left Resident #188's room with the uncovered needle. The sharp side of the needle was pointed directly down. LPN #2 walked directly across the hall to the medication cart,		of said monitoring will be reviewed as a part of the facility's monthly QA meeting on a permanent basis. 2) The Pharmacy is now supplying self-retracting needles for this medication, and shall do the same for all injectable medications for which a needle and syringe are supplied. It has been a long standing practice for the facility to purchase only self-retracting needles for use for all injections. Thus, this problem has been permanently rectified. Additionally, a copy of the instructions for the use of this partcular needle/syringe has been placed in this Resident's Medication Administration Record. Additionally, Administrative Nurses will conduct weekly observations of the administration of injections to random nurses to ensure that proper procedure is being followed. The DON will monitor. The results of said observations will be reviewed during the monthly QA meetings. This practice will continue for no less than six months. At the end of the six month observation period the QA Committee will determine the need to continue with this endeavor. The criteria for discontinuance of the observations at the end of the six month period will be as follows: Achievement of 100% compliance with all observations of the sixth months will be	

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	which was located approximately 12 feet away, where she disposed of the needle in the sharps container attached to the side of the medication cart. LPN #2 indicated, "I wish this kind had the retractable top, I don't like that it doesn't have that." In an interview with the A.D.O.N., on 8/8/2013 at 10:16 am, indicated sharps precautions are covered in orientation. A policy, provided by the A.D.O.N., on 8/8/2013 at 10:35 am, indicated, "Standard Precautions Policy...6. Westminster Village North's Standard Precautions Policy also included the following effective precautions: f. Needles (uncapped and unbroken), sharps and lancets shall be placed in a puncture-resistant container...It is the policy of Westminster Village North to use Safety Shield Needles or Needles with Sheaves to protect employees from needle sticks." 3.1-45(a)(1) 3.1-45(a)(2)		considered sufficient evidence to cease the observations.	

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F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to cover refrigerated food and keep the dry storage area in a condition which protects stored foods from potential infestation. This had the potential to affect 98 residents who eat food from the kitchen. Findings include: A tour of the kitchen was conducted on 8/6/13 at 12:00 p.m. The FSD (Food Services Director) was present in the kitchen during this tour. The Dry Storage Area was observed with a red, pasty substance splattered down the front left wall in 4 parallel streaks behind a metal food rack, clearly visible upon observation of the wall. The FSD touched the substance and stated, "I don't know what it is. It feels like tomato juice, maybe. It's dried on there." White granulated sugar was observed lying on a 25 lb. bag of flour on a bottom	F000371	The red pasty substance on the wall and residual sugar that was observed lying on the bag of flour were removed immediately after the initial inspection. The 3 packets of dressing, 1 ketchup packet, and 1 Sweet & Low packet, all of which were sealed closed, were picked up and disposed of while the surveyor was still in the kitchen. In addition, the pans of frozen vegetables that were observed uncovered were immediately covered. At the time of the survey, the facility practice was to clean the dry storage room on a daily basis. At the time of the surveyor's observation, the dry storage room had not been cleaned for the day. Subsequest to this citing, however, the cleaning schedule has now been increased to three times a days. As a means to prevent this from reoccurrence, inservices will be conducted for the staff on the proper cleaning of floors and walls, and on the proper covering and storing of food. Going forward, a new checklist will be posted for the responsible staff to initial after the walls have been	08/30/2013

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	food rack. The FSD indicated this was "residual sugar" from a bag of sugar. He then lifted a bag of sugar. Three packets of dressing,1 wedged between a rack and the floor, 1 ketchup packet, and 1 Sweet n Low packet was observed on the floor. The FSD indicated the dry storage room was cleaned daily. He indicated a metal box located under one of the food storage racks was a pest control mouse trap. He stated, "We haven't had any mice problems in 4 or 5 years." A refrigerator was observed with 4 large metal pans of uncovered broccoli and 4 large metal pans of uncovered carrots. The FSD stated, "They should be covered." The Dry Storage Areas policy was provided by the FSD on 8/7/13 at 3:00 p.m. It indicated, "Dry storage areas will be kept in a condition which protects stored foods from infestation...Floors must be swept clean at all times and mopped at least weekly." 3.1-21(i)(3)		inspected and cleaned and floor cleaning has been completed following breakfast, lunch, and dinner meal periods. The Food Service Director and/or Supervisor will be responsible for the daily monitoring of this procedure and will review the daily check sheet. The Food Service Director or Supervisor will report on the results of said monitoring during monthly Quality Assurance meetings.	

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R000000	The following state residential findings are cited in accordance with 410 IAC 16.2-5.	R000000	Submission of this plan of correction shall not constitute or be construed as an admission by Westminster Village North that the allegations contained in this survey report are accurate or reflect accurately the provision of nursing care and service to the Residents at Westminster Village North.	

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R000148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation and interview, the facility failed to ensure the environment was free of safety hazards, related to an unlocked mechanical room containing hazardous chemicals on the Ironwood Memory Care Unit. This deficient practice had the potential to affect 11 of 11 residents on the Ironwood Memory Care Unit. Findings include: During environmental tour on 8/05/13 at 12:10 p.m., on the Ironwood Memory Care Unit, the door to the mechanical room was not closed all	R000148	At the time of discovery the door was secured shut. Please note that no residents were affected.Subsequently, a door closure mechanism was installed on the door so that the door would automatically close shut after exiting. This was immediately corrected following its discovery. Additionally, all doors to rooms that contain chemicals were inspected to ensure that door closures were in place and functional, rendering the doors to positively latch. Maintenance personnel will be responsible to monitor the mecahnical room door on a weekly basis. The maintenance supervisor will monitor. The	08/30/2013

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	the way, and could be opened by pushing the door. This room was adjacent to the activity/dining room of the unit. The following items were inside the room, on shelves: Disinfectant Spray with warnings of eye irritant, and if swallowed, drink water and call physician; Novus #1 Plexiglass Cleaner, with the warning to contact local poison control center if swallowed; Stainless Steel Cleaner, oil based, with the warning "harmful or fatal if swallowed." Interview with the Maintenance Supervisor, at this time, indicated the mechanical room door should be closed and locked. Interview with the Ironwood Memory Care Unit Charge Nurse on 8/05/13 at 3:25 p.m. indicated 11 ambulatory residents reside on the unit.		results of said monitoring will be reviewed during the facility's monthly QA meetings. Said review will become a part of the permamnent agenda for the monthly QA meetings. Furthermore, as a means of on-going quality assurance, the inspection of such doors will be added to the safety audit sheets that are utilized by the safety committee so as to monitor the efficacy of the door closure mechanisms to the doors of rooms that contain chemicals. The results of the audits will be discussed every other month at each Safety Committee Meeting going forward.	

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R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to cover refrigerated food and to ensure a trash receptacle was covered when not in continuous use. This had the potential to affect 80 residents who eat food from the kitchen. Findings include: A tour of the kitchen was conducted on 8/6/13 at 12:00 p.m. The FSD (Food Services Director) was present in the kitchen during this tour. A refrigerator was observed with 4 large metal pans of broccoli and 4 large metal pans of carrots uncovered. The FSD stated, "They should be covered." An uncovered trash can, not in use, was observed with trash 3/4 full under a metal counter. Immediately above the trash can, on the counter, were 5 uncovered pies. The FSD put the cover on the trash can at this time.	R000273	It has always been the practice to ensure that a trash receptacle is covered when not in continuous use. At the time of discovery, during the survey process, the uncovered trash can was covered. Additionally, the pans of frozen vegetables that were observed uncovered were immediately covered. To prevent reoccurrence, inservices will be conducted on the proper use of lids on the top of all trash cans. Inservices will also be conducted on the proper covering and storage of food. Going forward, the Food Service Director and/or Supervisor will be responsible for the daily monitoring of this practice by visually inspecting during meal prep times. The Food Service Director and/or Supervisor will resport on said monitoring during the facility's montly Quality Assurance Meetings.	08/30/2013

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